



1. Project Data

Project ID P148052	Project Name TD Mother & Child Health Services Strengt
Country Chad	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s) IDA-H9610,TF-17138	Closing Date (Original) 30-Sep-2018	Total Project Cost (USD) 16,938,954.07
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Bank Approval Date 29-May-2014	Closing Date (Actual) 15-Jun-2020
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	IBRD/IDA (USD)	Grants (USD)
Original Commitment	15,790,000.00	5,000,000.00
Revised Commitment	18,580,605.17	2,790,605.17
Actual	16,938,954.07	2,790,605.17

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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement dated 6/20/2014, p. 4, the objective of the project was to increase the utilization and improve the quality of maternal and child health services in targeted areas.

b. Were the project objectives/key associated outcome targets revised during implementation?

No



c. Will a split evaluation be undertaken?

No

d. Components

1. Improving accessibility and quality of maternal and child health (MCH) Services through performance-based financing (PBF) and community health (Appraisal US\$17.8 million; Actual US\$11.5 million).

Sub-component 1.1: Provision of PBF grants and expansion of PBF through health facilities delivering service packages comprising preventive and curative services with a focus on MCH.

Sub-component 1.2: Governance of PBF purchasing arrangements, including supervision of health facilities, verification and counter-verification of PBF results after payments, and delivery of technical assistance to rural health facilities.

Sub-component 1.3: Development of community-based approaches for MCH services. Review of community-based approaches and training of community health workers for door-to-door visits and service delivery.

2: Strengthening institutional capacity to implement and sustain PBF and community-level health care services (Appraisal US\$2.99 million; Actual US\$4.3 million).

Sub-component 2.1: Strengthening institutional capacities for improved program and sector management, including organizing fora and workshops to advance the policy reform agenda, improving the quality and availability of essential medicines, and allocation of human resources.

Sub-component 2.2: Strengthening capacities for monitoring and evaluation (M&E), supervision, and project implementation. This included financing of project management and supervision, M&E, reviews conducted by the External Evaluation Agency, use of web applications on project performance, and covering costs of the impact evaluation.

Revised Components

A project restructuring on 6/28/2018 maintained the original components and added two more in response to government needs in addressing weak capacity in immunizations and emergency obstetric and neonatal care programs that impeded overall improvements in MCH outcomes. The two additional components consisted of the following:

3. Strengthening the delivery of the Expanded Program of Immunization (EPI) and emergency obstetric and neonatal care (EmONC) (Allocation US\$5 million; Actual US\$5 million). The component was to finance cold chain equipment, solar refrigerators and motorbikes for the EPI program, national and sub-national immunization campaigns, and training of health personnel on EmONC, where training was



delivered by the World Health Organization. The distribution of related supplies was undertaken by UNICEF.

4. Contingency emergency response. This fourth component aimed at facilitating the government response to any public health emergency or disease outbreak if the need arose. No upfront allocations were made, but the component would allow support for mitigation, response, and recovery in affected districts, with disbursements to be made against a list of goods, works, and services.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Cost and financing. The estimated cost at appraisal was US\$20.8 million consisting of an IDA grant of SDR 10.2 million (US\$15.8 million equivalent) and another grant of US\$5 million from the Multi-Donor Trust Fund for Health Results Innovation (HRITF). No direct counterpart financing was planned or provided. The total actual cost was US\$19.7 million.

Dates. The project appraisal document was finalized on 5/6/2014. Financing was planned for a four-year implementation period ending on 9/30/2018. The project was approved on 5/29/2014 and became effective on 9/18/2014. A Mid-term Review was carried out on 2/23/2018. A first restructuring on 6/28/2018 revised components, allocations, and the results framework, and extended the closing date to 7/31/2020. A second restructuring moved up the closing date to 6/15/2020.

3. Relevance of Objectives

Rationale

Project objectives were responsive to important health sector challenges combining aspects of accessibility, affordability, and quality of services. Utilization of existing health services, notably at the primary level of health care, was very low. For example, there were only 0.18 contacts per year and per child. The maternal mortality ratio, estimated at 1,100 deaths per 100,000 live births in 2010, was the highest among Central African countries, and the infant mortality rate was estimated at 98 per 1,000 live births (PAD, pp. 1-2). High fertility and gender inequalities were salient, and the Human Development Index ranked Chad at 183 out of 187 countries in 2011. Half of the population lived on less than US\$1.25 per day.

Prior to the project during the period between October 2011 and March 2013, the government carried out a pilot PBF scheme in eight health districts across four regions covering a total population of 1.45 million people. The pilot included a basic package of health services delivered at health centers, a complementary package of services delivered at district hospitals, and the introduction of a quality checklist for services. Pilot results showed an increase in service utilization with doubling of attended deliveries and immunization rates (PAD, pp. 4-5).



During project preparation, the Bank did not have a Country Partnership Framework in place. An Interim Strategy Note was developed for the period 2010-2012, followed by a 2013 Joint Staff Advisory Note that was aligned with Chad's National Development Plan for the period 2013-2015, in which human capital development was among its eight pillars. A subsequent national plan for 2018-2020 was developed. Both national plans focused on improving equitable access to quality health services and prioritizing MCH. The objectives were aligned with the National Health Policy 2016-2030 that set a vision for building an integrated, well-performing, resilient, people-centered system. The National Health Policy underlined the need to ensure access to health services for the most vulnerable groups in order to promote equitable access to quality health services.

At project closing, development objectives remained consistent with the Country Partnership Framework (CPF) 2016-2010. The CPF had three engagement themes: (1) Strengthening management of public resources; (2) Improving returns to agriculture and building value chains; and (3) Building human capital and reducing vulnerability, under which one of the CPF objectives was to improve rural access to reproductive health services. The project was listed by the CPF as an ongoing operation contributing to the CPF objective on improving access to reproductive health services.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Increase the utilization of maternal and child health services in targeted areas

Rationale

Explanation of targeted areas. The project focused on 12 health districts in five regions (Batha, Guera, Logone Oriental, Mandoul and Tandjile). The five regions were selected on the basis of: (i) high poverty rate; (ii) status of health indicators; (iii) presence of other development partners; and (iv) logistical and technical capacity to implement PBF. Four of the regions participated in a previous PBF pilot, as previously noted in Section 3. The beneficiary population included approximately 2.2 million inhabitants (2014) in the five selected regions. Main beneficiaries were women of reproductive age (including young women, pregnant women, and mothers) and children.

Theory of change

It was reasonably expected that PBF payments to health facilities, as well as provision of bonuses promoting motivation, training of personnel, training of community health workers, strengthened management and



supervision, verification of results, and the use of quality checklists for services would result in increased utilization and quality of MCH services.

There were some gaps in the theory of change. Addressing demand-side aspects is an important contributor to utilization, as the latter is a function of both supply and demand aspects. In this context, 'information, education and communications' activities were lacking, even though barriers to demand, such as socio-cultural barriers, were known (ICR, p. 48). Also, the full extent of the desired change was not clear, as the planned achievement targets were reflected in absolute numbers without information on the proportion of users that the project was striving to reach.

Outputs and intermediate results

The number of health personnel receiving training reached 516 persons in 2019, short of the target of 1,000 persons. Most of the training was undertaken in the latter part of the project period, as only 1.4 percent of the target was reached by May 2018 at project restructuring (ICR, p. 54). The indicator on health personnel receiving training was not clearly described in terms of targeted cadres or training content. Given that other intermediate indicators also referred to staff training, the ICR (p. 40) stated that there might have been an overlap between related indicators. As a non-PBF-related output that aimed at increasing utilization, Community Health Workers were trained for delivering an integrated preventive and curative package at the household level. The number of trained workers reached 1,492 workers in 2019, exceeding the target of 500 workers.

The following results were specific to project areas:

The number of women of reproductive age using modern contraceptive methods increased from 7,916 in 2014 to 108,947 women in 2019, exceeding the target of 14,000 women.

The number of children under five years of age receiving preventive nutrition services increased from a baseline of 23,483 children in 2014 to 95,486 children in 2019, exceeding the target of 50,000 children.

The number of people who received essential health, nutrition, and population services under the project was 258,917 in 2019, exceeding the target of 98,600 people.

The number of women and children who received basic nutrition services under the project reached 95,486 in 2019, exceeding the target of 38,600 women and children.

Outcomes

Reported results, specific to project areas, showed the following:

- An increase in the number of pregnant women who received antenatal care during a visit by a health provider from 48,300 women in 2014 to 171,460 in 2019, exceeding the target of 80,000 pregnant women.



- An increase in the number of births through deliveries attended by qualified health personnel from a baseline of 20,836 attended births in 2014 to 70,872 attended births in 2019, exceeding the target of 35,000 attended births.
- An increase in the number of children immunized (DPT3) from a baseline of 15,389 children in 2014 to 92,604 children in 2019, exceeding the target of 25,000 immunized children.

In terms of volume of services, the results indicated that the project contributed to increased utilization of MCH services in project areas. However, there were gaps in the evidence and some concerns regarding plausible contribution by the project. First, and as noted above in the theory of change, the project lacked information on the proportion of people utilizing MCH services. The ICR (p. 21) stated that, while utilization targets were surpassed, coverage of essential health services in project areas remained low by regional and international standards, but the ICR did not provide further details. Second, there was a lack of information that would enable comparison of areas or groups covered by the project with areas or groups not covered by PBF. In this context, the ICR (p. 48) noted that it was very difficult to ascertain that improvements in service utilization plausibly could be attributed to PBF payments. Third, another reservation regarding plausible contribution arises from the fact that several project targets were met by the original closing date of September 2018 (ICR, p. 25), and yet, PBF activities started only in March of the same year (ICR, p. 32).

An additional shortcoming was that the project did not comply with the triggered safeguard policy on Environmental Assessment OP/BP 4.01 (see Section 10a).

On balance, taking into consideration exceeded achievement targets and the shortcomings discussed above, the achievement of Objective 1 is considered borderline substantial.

Rating

Substantial

OBJECTIVE 2

Objective

Improve the quality of maternal and child health services in targeted areas

Rationale

Theory of change: same as above under Objective 1.

Outputs and intermediate results

The following results were specific to project areas:

The number of health centers and district hospitals that had Basic Emergency Obstetric and Neonatal Care reached 65 centers in 2019, short of the target of 150 centers.



Staff in health centers and district hospitals who received training in Emergency Obstetric and Neonatal Care reached 130 staff in 2019, short of the target of 203 staff.

The percentage of tracer drugs available in targeted health facilities on the day of the visit increased from a baseline of 50 percent in 2014 to 100 percent in 2019, exceeding the target of 75 percent.

The percentage of health facilities reporting monthly activities was universal at 100 percent in 2019 compared to a baseline of 65 percent in 2014, exceeding the target of 95 percent.

The number of health centers and districts that received cold chain equipment reached 155 centers, exceeding the target of 134 facilities.

Outcomes

The average score of the quality checklist reached 65.4 percent in 2019, exceeding the target of 30 percent.

Explanation of quality checklists and their utilization:

Checklists were used to assess overall quality of services and to identify specific areas for improvement on a periodic basis. Checklists provided an index encompassing the calculation of an array of quality aspects:

1. At the health center level, the checklist covered 12 areas: maternal care, antenatal care, family wellbeing, immunization and preventive child health services, general activities, surveillance and data management, hygiene and environmental health, outpatient services, tuberculosis and leprosy, minor surgery, drug management, and financial management. General activities covered the availability of information at the facility such as opening times and fee schedules, availability of a phone or radio, and development of an action plan for the semester. For service-related areas, indicators covered themes such as privacy, availability of critical supplies, and compliance with clinical guidelines and standards.
2. At the hospital level, the checklist covered 16 areas, mostly linked to hospital wards: maternity, urgent and emergency care, pediatrics, gynecology, operating block, blood transfusions, general medicine, surgery, outpatient care, hygiene, maintenance, pharmacy, sterilization, laboratory, imagery, and hospital administration (ICR, p. 21).

However, since PBF payments were stopped in April 2019, no data on the quality of care were collected after April 2019 through project closing in June 2020. The ICR (p. 45) noted that there were good reasons to believe that service quality would drop, including because staff hired under PBF might not be retained, and the absence of staff bonus payments would have reduced staff motivation to comply with all requirements to deliver quality health services.

Rating
Substantial



OVERALL EFFICACY

Rationale

The aggregation of achievements under the two objectives to increase utilization and to improve the quality of MCH services in targeted areas indicate that the objectives were almost fully achieved, with some shortcomings, consistent with a substantial rating for overall efficacy.

Overall Efficacy Rating

Substantial

5. Efficiency

Adequately applied interventions in MCH are generally considered cost-effective in the global literature. Findings from studies in low and middle-income countries on the cost effectiveness of MCH interventions vary on average between US\$82-142 per DALY averted (Disease Control Priorities, Second Edition, 2006).

At appraisal, a cost-benefit analysis was carried out. The analysis considered direct costs of the PBF component, excluded the community health component due to the lack of data, used a social discount rate of 5 percent, and assumed a budget execution rate of 80 percent. The analysis estimated a Net Present Value (NPV) of US\$3.23 million. The ICR (p. 18) carried out an ex-post economic analysis following the same methodology adopted at appraisal, and it updated the estimate of NPV related to PBF at US\$20.2 million. A sensitivity analysis was also conducted for a second scenario with a discount rate of 3 percent, yielding an NPV of US\$21.64 million and a benefit-cost ratio of 6.1; and for a third scenario with a discount rate of 10 percent, corresponding to an NPV of US\$17 million and a benefit-cost ratio of 6.5, indicating that benefits outweighed the costs.

However, there were shortcomings in the efficiency of implementation ranging from significant to major. Significant operational delays hindered the start of key PBF activities such that implementation on the ground began only in the fifth year of the project (2018), along with the protracted signing of a contract with an Independent Verification Agency. The ICR (p. 36) noted that the delays in recruiting and maintaining the verification agency posed major challenges to PBF implementation. Hence, PBF services were implemented only for a short period of time in 2018 through April 2019, at which date PBF payments were stopped due to insufficient financial resources (Restructuring Paper of 6/18/2020, Report No. RES41497, p. 3). Subsequently, only a few activities happened on the ground during the last year of the project until its closing date on 6/15/2020. According to the ICR (p. 66), extended implementation delays during the initial four years were characterized by very weak government ownership. Opening of bank accounts for health facilities required an official act certifying that a health facility had been created by the government (ICR, p. 26). Disbursements between 2014 and 2018 were minimal, as reflected in the ICR's Figure 4 (ICR, p. 31).

The project underestimated the cost of PBF, and verification costs alone represented 54 percent of the PBF budget, with another 30 percent for administrative costs (ICR (p. 35)). These issues resulted in a financing envelope that was insufficient to implement PBF for the full duration of the project. Health facilities were unable to retain related staff. A fiduciary team was not in place during the first three years of project implementation



(ICR, p. 43). Financial management performance remained unsatisfactory or moderately unsatisfactory for the better part of the project (ICR, p. 43). Internal control was weak with significant deficiencies in internal auditing.

Counter-verification did not occur because of insufficient funds (ICR, p. 36). The planned impact evaluation was not carried out. The project did not have enough resources to renew the verification contract, and the government hired individuals to verify results for a duration of four months after which PBF payments were stopped. The planned review of community-based approaches was not undertaken. Project funds were understandably used to mitigate outbreaks of cholera and hepatitis, but this further reduced scarce resources intended to support original project activities (ICR, p. 25).

At the institutional level, the PBF Steering Committee was not functional for four years between 2014 and 2018, and the PBF Technical Unit (that served as the Project Implementation Unit, according to the PAD, p. 14, and Task Team clarifications of 1/27/21) was not manned (ICR, p. 32). Oversight was slight and there was no effective platform to deal with arising challenges or to adopt timely corrections. According to the ICR (p. 32), the PBF Steering Committee was in breach of the principles stipulated by the Financing Agreement because it was chaired by the General Director of Health Activities instead of the General Secretary at the Ministry of Public Health, and this arrangement impacted implementation because the project did not have sufficient visibility at the senior management level. The PBF Steering Committee was reformed shortly before the 2018 project restructuring. It was chaired by the General Secretary at the Ministry of Public Health, after which it became functional.

Staffing issues were salient, notably at the Project Implementation Unit. The delay in hiring a PBF specialist led to a decision to eliminate this position. Other key positions were vacant, and turnover was high. The project had three different Project Coordinators between 2014 and 2017. There were concerns regarding the performance of key staff during the project's initial years. The ICR stated that the Project Implementation Unit identified constraints on the ground, but that there was no evidence that issues were effectively addressed or that support was provided for developing action plans to facilitate implementation (ICR, p. 37). Access to facilities in the southern provinces was difficult due to flooding during the rainy season, preventing effective field supervision for both the Project Implementation Unit and the Bank team, and making visits costly and challenging. Flooding limited the number of people utilizing health services. The general security situation in Chad also imposed restrictions and complicated logistics.

Efficiency Rating

Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable



* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives is rated high, as objectives remained closely aligned with the Bank Group Country Partnership Framework FY16-20, the country's National Development Plan 2018-2020, and the National Health Policy 2016-2030. Efficacy is rated substantial as the objectives were almost fully achieved, with some shortcomings. Efficiency is rated modest because the project was not efficiently implemented, with significant and major shortcomings in the efficiency of implementation. Therefore, the overall outcome is rated moderately satisfactory, indicative of essentially moderate shortcomings in the project achievement of its objectives, in its efficiency, or in its relevance.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

The main risk that development outcomes may not be maintained relates to financial constraints. It is likely that project achievements would be affected over time by the discontinuation of activities, non-retention of staff mobilized under PBF, reduction of funding to the regions, and loss of credibility due to the cessation of PBF. No data on the quality of care was collected after PBF payments were stopped. Another risk is that PBF could be perceived as a pilot or a donor-driven intervention, thus reducing opportunities for its institutionalization.

At the same time, some of the project interventions may have a sustained positive impact. The increased autonomy of health facilities may empower them to proactively make decisions to deliver adequate services. Staff competencies and M&E processes have been strengthened. Facilities have been equipped with solar fridges and motorbikes, and relevant staff were trained to tackle overall maintenance.

The government requested the preparation of a new project for extending PBF, and the proposed follow-on operation would be implemented in areas covering 6.7 million people (Health System Performance Strengthening Project, P172504, planned for Q3 of FY21 per Task Team clarifications of 1/27/2021). Also, the government has included PBF as one of the main health financing mechanisms in its National Universal Health Coverage Strategy. The ICR indicated that both government and Bank teams were working on a Development Policy Operation that would include actions related to the institutionalization of PBF, including by using government funding.

8. Assessment of Bank Performance

a. Quality-at-Entry



The design of the PBF model built on lessons from a previous PBF pilot, including lessons related to institutional arrangements and autonomy of health facilities, and the use of PBF subsidies and incentives (ICR, pp. 28-29). The project did not have specific interventions to address socio-cultural barriers to demand (ICR, p. 48), nor activities to support coordination with community-based platforms such as the supervision of Community Health Workers by facility staff (ICR, p. 30).

Project preparation took only six months, as it was accelerated with a valid aspiration to reduce the time gap between the pilot and the project. However, the accelerated pace contributed to gaps in readiness for implementation. The ICR noted that more preparatory steps could have been taken to advance the recruitment of the Independent Verification Agency, such as drawing up and validating terms of reference, and assessing local and international markets for verification service providers. The subsequent delay in recruiting the verification agency emerged as a major bottleneck to PBF implementation.

A recently updated National Medical Waste Management Plan was to be used in the context of environmental safeguards. Financial management was the responsibility of the General Directorate for Resources and Planning (PAD, p. 20). The financial management assessment at appraisal concluded that the directorate had reasonable experience in donor-financed activities, but that it did not fully meet the necessary requirements in know-how and capacities. According to the ICR (p. 44), the PAD did not have sufficient information on how the project would strengthen fiduciary capacities, as the risk of low capacities posed a major challenge to timely and effective implementation in compliance with World Bank policies and guidelines. PBF costs were underestimated, although the project planned for full costing to be undertaken in the early stages of implementation. In addition to important shortcomings in readiness as noted above, there were shortcomings in M&E design that are discussed in Section 9a.

Quality-at-Entry Rating

Moderately Unsatisfactory

b. Quality of supervision

The Bank team conducted implementation support visits to Chad on a biannual basis. No dedicated staff was based in the country. The Bank team's early implementation support visits focused on establishing adequate implementation arrangements and developing the concept of an impact evaluation (ICR, p. 44). Such activities are normally expected to be fulfilled during project preparation. Subsequently, the focus shifted to unblocking bottlenecks that caused implementation delays.

The ICR (p. 38) noted that there was no evidence to suggest that the Bank reacted proactively to address implementation challenges that were within its control during the first years of implementation. Changes in the composition of the task team (the project had five TTLs, including co-TTLs) resulted only in marginal progress. According to the ICR (p. 36), weak progress during the project's first years would have merited more frequent implementation support visits to the country. Implementation support visits would have provided an opportunity to facilitate the strengthening of managerial capacities and to actively support government counterparts in the development of action plans to accelerate implementation. There was no evidence that such support was provided (ICR, p. 37). The ICR also noted that there was no evidence that relevant support resources were mobilized, particularly in the areas of procurement and financial management, to accompany the Project Implementation Unit counterparts and to facilitate the completion



of essential tasks such as in the development and management of contracts. The ICR also stated that the delay in the recruitment of the verification agency could have been prevented by more active fiduciary support.

Nevertheless, the proactiveness of the Bank's implementation support improved during the life of the project (ICR, p. 44), and the Bank team facilitated a Mid-Term Review in February 2018, followed by two project restructurings, the first of which contributed to accelerating the pace of implementation. According to the ICR, assessments by the fiduciary team pointed to some of the most salient weaknesses in project implementation, and the fiduciary team brought up their concerns during the Bank's portfolio review, thus providing an opportunity to increase the visibility of shortcomings to reach government officials at the central level.

There were shortcomings in the quality of reporting. While ISRs and Aides-memoire were candid about the challenges being faced (ICR, p. 37), there was inconsistency between the findings and ratings, and monitoring documents did not provide clear follow-up on actions and potential solutions or sufficient information on the persistence of implementation challenges.

Supervision of safeguards was inadequate. The ICR (p. 45) reported that there was no evidence in the ISRs that issues around the development of safeguards were adequately documented, that the first and only reference to safeguards appeared in the 6th ISR, and that the project did not develop guiding documents for the management of risks. Issues related to non-compliance with safeguards are discussed in Section 10a. According to the ICR (p. 42), the project also did not comply with the requirement to develop an Environmental and Social Management Framework, and its absence impeded the identification of risks. According to the ICR, this also meant that the project did not have any guidance on how to manage risks and how to conduct important processes such as public consultations and management of grievances. No ratings for safeguards were reported in the Bank's Operations Portal.

Quality of Supervision Rating

Moderately Unsatisfactory

Overall Bank Performance Rating

Moderately Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The objectives were clearly stated. The objective to improve the quality of services was well captured by an index indicator reflecting an array of quality aspects, while the utilization objective was captured in terms of volume of services delivered, but lacked coverage measures that were needed to demonstrate achievements in terms of proportions among targeted populations.

According to the ICR (p. 40), there were shortcomings in intermediate results indicators. For some, there was insufficient information on how indicators were calculated. The indicator on health personnel receiving training was not clear, as there was no indication on personnel cadres to be trained or on training content.



Some baselines were available, and others were to be determined through a baseline survey that was planned shortly after effectiveness.

The Ministry of Public Health was responsible for M&E. It planned to use data from several sources: the existing Health Management Information System, PBF data collected by health facilities, verification data, and a planned impact evaluation whose objectives were to: (i) identify the effects of PBF on MCH services; (ii) identify key factors responsible for the project's observed outcomes; and (iii) assess the cost-effectiveness of PBF as a strategy to improve coverage and quality (PAD, p. 15).

b. M&E Implementation

Important milestones in M&E implementation did not take place (ICR, p. 41). The baseline survey was not carried out. The counter-verification of results did not take place. This was explained by the lack of sufficient funds to hire a counter-verification agency (ICR, p. 36). The impact evaluation was not undertaken. Issues related to verification were noted in Section 5. When PBF data became available in the latter part of the project, progress was reported through a web-portal dedicated to the project.

c. M&E Utilization

M&E data were used for project monitoring and PBF payments. According to the ICR (p. 41), there was no evidence that central level officials accessed project data to inform their regular discussions, but M&E findings helped in designing the restructuring of the project, including for strengthening immunization capacity and emergency obstetric and neonatal care.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project triggered safeguard policy OP/BP 4.01 on Environmental Assessment, under which the project was classified as Category B in view of increased risks of health care waste. The project planned to use the National Medical Waste Management Plan, that was reviewed, consulted upon, and revised during preparation. It was disclosed in April 2014 (Integrated Safeguards Data Sheet, p. 5, 4/18/2014).

Implementation was limited to the period between 2018 and project closing in June 2020 (ICR, p. 42). Facilities were equipped with key supplies and equipment for infection control and prevention, including personal protective equipment and waste management equipment. Health facilities used PBF subsidies to procure some of these supplies. An environmental and social audit conducted at project closing provided information regarding compliance with environmental safeguards and the extent to which the plan was effectively implemented. According to the ICR (p. 42), the audit concluded that the plan was not available in about 80 percent of the facilities in the audit sample, that a large share of health facilities had incinerators that were not functioning, and that 80 percent of the facilities did not have qualified staff to operate them.



The ICR also stated that the project did not comply with the requirement to develop an Environmental and Social Management Framework (see section 8b).

b. Fiduciary Compliance

Financial management performance was deemed to be in the unsatisfactory range during most of the project period, and the Project Implementation Unit did not have a fiduciary team in place during the first three years of the project. Bank statements were not reconciled. There were significant weaknesses in the management of fixed assets and significant delays in the submission of audit reports. Performance improved moderately after the recruitment of the fiduciary team in 2017, but weaknesses persisted with weak internal control and internal auditing deficiencies. In procurement, one noteworthy issue was the delayed recruitment of a verification agency as previously discussed in Section 5. The ICR (p. 42) stated that, with active support from the task team procurement specialists, the project complied with World Bank procurement policies and procedures.

c. Unintended impacts (Positive or Negative)

The project undertook environmentally friendly actions such as the use of solar panels for health facilities and the distribution of solar fridges that reduced the consumption of electricity (ICR, p. 27).

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Moderately Satisfactory	This ICR Review rated efficiency as modest because the project was not efficiently implemented, with significant and major shortcomings, including very high verification and administrative costs, and discontinuation of PBF health services.
Bank Performance	Moderately Satisfactory	Moderately Unsatisfactory	This ICR Review rated both Quality-at-Entry and Quality of Supervision as moderately unsatisfactory because of



significant shortcomings, including lack of readiness, insufficient implementation support and proactiveness, and inadequate follow-up and reporting on the project's non-compliance with the environmental safeguard policy.

Quality of M&E	Modest	Modest
Quality of ICR	---	Substantial

12. Lessons

The ICR (pp. 46-49) identified a few lessons and provided relevant recommendations, including the following lessons re-stated by IEG:

Increasing financial autonomy of health facilities contributes to improvements in the quality of services. Under the project, and in addition to the use of service quality checklists, a large number of health facilities used PBF funds to mobilize additional human resources, provide bonuses that motivated staff to enhance performance, purchase drugs that were out-of-stock in the mainstream system, facilitate mobility for outreach services, and undertake infrastructure repairs.

Putting in place basic implementation arrangements to promote project readiness is equally important to the development of substantive technical designs. Under the project, preparation revolved around technical design, and relatively less on routine implementation arrangements and processes. Funds could not adequately flow until basic implementation arrangements were in place. A 4-year delay in recruiting an independent verification agency hindered PBF rollout and could have been curtailed with certain preparatory steps, such as drawing up and validating terms of reference, assessing of local and international markets for verification service providers, and engaging senior government decision-makers on the importance of a timely process for approvals and contracting.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was results-oriented and very candid. It provided a complete critique of the project. Its analysis was thorough, although, at times, the ICR's conclusions were not fully in line with its findings. The quality of evidence was uneven, but shortcomings originated from the project itself and not from the ICR, that aptly analyzed and highlighted related weaknesses. The Review was internally consistent with occasional lapses,



such as in timelines or ambition levels. The ICR offered relevant recommendations and multiple lessons, although the latter often reflected findings rather than lessons. The ICR followed guidelines, but the quality of its substantive contents was moderated by a lengthy narrative that was not tightly written, with repetitions, resulting in a main text of 49 pages.

a. Quality of ICR Rating
Substantial